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CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 15.1
TITLE: EVALUATION AND MANAGEMENT SERVICES (OFFICE VISITS) GENERAL

AUTHORITY: 38 CFR 17.270(a) and 17.272(a)

RELATED AUTHORITY: 32 CFR 199.4(c)(2)(iv)

I. EFFECTIVE DATE

Effective January 1, 1998.

II. PROCEDURE CODE(S)

77750-77799, 90801-90802, 90935-90947, 94010-94799, 95115-95180, 99050, 99052-99058, 99201-99215, 99321-99333, 99341-99350, 99358-99359, 99374-99375, and 99381-99397

III. POLICY

A. E and M (Evaluation and Management) services are covered when provided by an individual professional provider for the diagnosis or treatment of a specific illness or condition or set of symptoms. The E and M allowable amount is included in the procedure payment and will not be reimbursed as a separate charge.

B. Some E and M visit codes are classified as either “New” or “Established Patient”. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. Only one new patient visit for a beneficiary to a provider is covered.

C. Services will be processed and paid under CPT 99202 for a new patient and under 99213 for an established patient unless otherwise specified by a more complex CPT procedure code. If the claim does not specify whether the patient is new or established, the patient will be considered to be an established patient.

IV. POLICY CONSIDERATIONS

A. Reimbursement will be limited to the allowable charge for the E and M visit only (combine the charge and base payment on the maximum allowable charge for the E and M visit). No additional payment will be allowed when any of the services listed below are billed in conjunction with an E and M visit:

1. Minor dressing
2. Ostomy care
3. Prostate massage
4. Blood pressure determination
5. Topical 5-FU (fluorouracil) treatment
6. Eye washing
7. Ear irrigation
8. Pelvic examination
9. Rectal examination
10. Urethral catheterization
11. Removal of fecal impaction
12. Removal of cerumen
13. Cauterization of cervix by chemical agents
14. Cast application not involved with surgery
15. Dressing changes

B. When additional charges are made for services provided beyond the provider's normal treatment hours, CHAMPVA will reimburse for these charges up to the prevailing rates. Reimbursement will not be made for services at urgi-centers past normal treatment hours because they are an extended hour facility.

C. If multiple E and M services are billed on the same day by the same provider only one E and M service (the one with the highest prevailing rate) will be paid, unless as described below. If review indicates that such services were billed by different professional provider's, each will be payable.

Note: If an abnormality or a preexisting problem is encountered or addressed in the course of the office visit, and if the abnormality/problem is significant enough to require additional service, then modifier–25 could be added to the Office/Outpatient code. Modifier–25 is used to indicate that the same physician provided a significant, separately identifiable E and M service on the same day of the procedure or other service. (Example: A patient presents for a GYN exam and at the time of the office visit, the physician also removes a skin lesion on the arm.)

D. When a surgical procedure is performed at the time of an E and M service, only the surgical procedure is payable unless modifier–25 is used and review indicates that the patient's condition required the E and M service or a separate diagnosis justifies payment of the E and M service (see Chapter 2, Section 29.17, *Evaluation and Management Services (Office Visits) With Surgery)*.

E. For office visits billed in conjunction with PUVA therapy, (see Chapter 2, Section 30.11, *PUVA (Photodynamic Therapy and Photochemotherapy)*.

F. Medical visits will be denied when billed with specific non-surgical procedures.

V. EXCLUSIONS

A. E and M services for a routine physical examination are not covered (see Chapter 2, Section 23.2, *Routine Physical Examinations)*.

B. E and M visits related to a custodial condition are not covered.

C. Some procedures include routine E and M services and are not payable when billed with the following procedures codes: 77750-77799 (clinical brachytherapy); 90935-90947 (hemodialysis and miscellaneous dialysis procedures); 94010-94772 (pulmonary); and 95115-95180 (allergen immunotherapy).

END OF POLICY